Health Quality and Cost Council
Patient Centered Medical Home Workgroup
Payment Subgroup
Meeting Summary
August 4, 2009
9:00-10:30 a.m.
Via Teleconference

Purpose
This group will consider the costs of establishing a medical home and alternatives for reimbursing the medical home.

Discussion Summary
Following introductions, the meeting began with a discussion on the components of costs associated with establishing a medical home, or ongoing costs associated with maintaining a medical home. Typically, reimbursement could be differentiated by the three levels in the NCQA recognition program.
Most of the multi-state demonstrations make a statement that up to $5 PMPM is reimbursed, up to the level of the NCQA PCMH recognition that has occurred. There are also other factors differentiated by costs associated with risk. The only demonstration, or planned demonstration, in which risk is formally calculated in the PMPM reimbursement scheme is in the CMS demonstration, where they use the hierarchical classification which is used for the Medicare HMO Advantage Program to segment or assign risk categories for patients in the home. Specifically for multi-stakeholder demonstrations, risk has not been recognized. On average, the PMPM is awarded based on recognition level and would be thought to be covering a variety of lower and higher needs patients. The last factor that affects costs is how patients are attributed to a medical home. Typically, they are based on a plain look-back approach. Typically, across the country, the look-back is based on the plurality of E&M visits in a specified period to assign a patient to a home.

Dr. White asked for reaction from the payers regarding national experience on the average look-back. With regard to attribution and risk, United HealthCare has been using a two year look- back for the last few years on a number of different pilots. Two years of both medical and pharmacy claims help determine attribution. PMPM payments are not risk adjusted for any of the pilots, except by line of business. So, Medicare in one of the pilots is a multiple of the commercial, but Medicaid is somewhat less than the commercial. But in other pilots, the PMPM tiers up based on the NCQA level. It's not risk adjusted based on the patients' individual demographics or utilization. Aetna's perspective was that it is important that it is mapped out exactly how the attribution is going to occur so that it equitable among all of the plans.

Barbara Epke and Dr. White noted that care coordination goals would need a definition and established criteria for measurement. Discussion focused upon including a shared savings model for physician practices and payers. One issue to be considered regarding shared savings is how to deal with instances where there are no shared savings, but payments for primary care will have at least shifted away from, perhaps, facilities and avoidable acute care, to primary care. Most physician practices would prefer to determine the best way to allocate care coordination fees. Shared savings may not be evident for several years. There was additional discussion of an audit process and about what a formula would be as the practice improves.

The group then discussed whether the payers, as a group, could take on a modeling function to project cost savings. United HealthCare offered to give input on what they have modeled out so far.

The group then turned to a summary of the Massachusetts payment reform by Michael Bailit, which provides various models that have been used. A FFS PMPM payment with a performance-based reward is the standard model that has been endorsed by all three of the specialty societies that have been most active in the PCMH as well as the broad multi-stakeholder consortium. The pay for performance starts with a payment for quality, but evolves to a payment for quality and efficiency. Many of the demonstrations, including CareFirst's, start with a reward for quality improvement and then inject some efficiency measures at stage two. The definition of the efficiency measures is tied to a cost metric. A shared savings model would provide a proportional, and possibly larger, reward back to the practices. Most of the New England demonstrations have opted to carve out the care coordination from the PMPM.

There are no additional flagged FFS codes being paid for, such as E-visits and group visits and all the other types of virtual care. If all of the payers in these demonstrations turned on these additional codes on the front end and added the shared savings component on the backend, that might provide some more clarification to payers or providers.

United HealthCare's demonstrations in Rhode Island include all United enterprise membership regardless of Medicare or Medicaid or commercial. Aetna's Pennsylvania demonstration includes its whole product line.

Ms. Epke asked if there is a material incentive for patients in the Aetna or United HealthCare plans? Patient incentives are plan sponsor-specific in Aetna's plans. Certain employers have chosen to add incentives. United HealthCare offers some products where a patient selects a primary care physician and others where they do not. In general, the primary care physician copayment is usually less than the copayment to the specialty physician. It would be exceedingly difficult to lead with something like a change to the benefit structure, which would involve potential filings and going to customers and offering new products, which would be a one to three year cycle.

Performance that is centered around quality measures and FFS with a higher payment level seems reasonable from a practice's perspective. It's going to be challenging for many of the payers to determine who is a member of which practice and for how long because people move around all the time. So, the higher payment levels with a FFS encounter seem to make that a little smoother, though, it doesn't take into account the investment that a practice must make up front.

The HITECH and the state incentive payments for EHR adoption would be factored in as part of the financing support for medical home adoption. It's not explicit in HITECH, though it is somewhat explicit in the state bill that was passed in the last session. HITECH envisions a pay as you go formula, not a lump sum payment. A practice cannot operate as a medical home without an ERH. Some of the costs will be sustained through HITECH payments and some could be financed through the payer subsidy. The vendors are likely going to figure out flexible financing terms to sell these products, recognizing that there is a stream of money that is not going to be a lump sum. Where there is still a gap is in the transformation of practice personnel, training, etc. that is a significant productivity impact. Typically, the demonstrations are small because the cost of those transformations has been significant.

Dr. White summarized the group's deliberations: for the first tier: FFS, plus an EHR acquisition payment over time, plus a PMPM, plus pay for quality. For the second tier: a FFS, plus a PMPM, plus pay for quality or pay for performance, and shared savings.

Mr. Steffen added that the EHR acquisition, plus PMPM, plus some longer look-back for shared savings might be in the formula from the very beginning, but the evaluation of the savings would begin at year 2 and look back over an entire two year period for where there are savings that could be then distributed. An evaluation would not be made until the end of the second year, and then going forward, if it was a 3 year demonstration, a look back over the first two years to determine the savings and distribute them.

The group then discussed the expense of EHR. The practice transformation and the EHR acquisition costs are estimated to be $90,000.

A specific cost proposal will be considered at the next meeting of the Patient Centered Medical Home Workgroup.

Teleconference Participants

Council members: Kathi White, Ph.D., Chair, and Barbara Epke

Other participants: Nancy Creighton (Peninsula Regional Medical Center)Rex Cowdry (Maryland Health Care Commission), Richard Fornadel (Aetna), Edward Koza (United Healthcare), Mark Noveck (Coventry Health Plan), Deborah Neels (University of Maryland),Carol Reynolds (Potomac Physicians), Eric Sullivan (United HealthCare),

Staff: Ben Steffen, Karen Rezabek